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Implementing a Health and Safety Management System

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Introduction

Occupational injuries and illnesses in the United States result in nearly 2,800,000 lost workdays every year. In 2001, occupational injuries and illnesses cost U.S. employers an estimated $40,100,000,000. Internationally, even greater losses are observed.[1] These enormous losses (measured in lives and dollars) can be significantly reversed by implementing a health and safety management system such as the Occupational Safety and Health Administration's (OSHA) Voluntary Protection Program (VPP). Programs such as VPP have been shown to reduce occupational injuries and illnesses and their associated costs by approximately half (see sidebar on page 2).

Realizing these numbers and costs, many employers implement health and safety management systems in an effort to continuously improve their programs and save substantial money. To assist employers in these efforts, there are numerous guidelines and standards available. Some of the most prominent are:

- Voluntary Protection Program (Occupational Safety and Health Administration)
- Responsible Care (American Chemistry Council)
- Guidelines for Occupational Safety and Health Management Systems (International Labour Organization)
- Occupational Health and Safety Management Systems (British Standards Institution—OHSAS 18001)

There are other guidelines and standards for health and safety management systems from sources such as federally approved state OSHA programs, standards organizations (such as the International Standards Organization—ISO), industry groups, and private industry. Additionally, the American National Standards Institute (ANSI) has released a draft of the ANSI Z10 voluntary standard (titled Occupational Health and Safety Management Systems), which follows similar management system principles. Between the various guidelines for developing and implementing health and safety management systems, there are far more similarities than differences.

Evaluating a Company's Health and Safety Management System

Comparing an employer's existing system to any of the commonly used systems is an in-depth process. It involves an objective (and perhaps an outside and/or independent) review of heath and safety-related policies, procedures, and records. It also includes interviews with senior and middle management, supervisors, and line/hourly employees. Finally, it requires a detailed survey of the facility to identify potential hazards and determine if they are adequately controlled. The order of these activities varies and may alternate during an individual project.

In addition to evaluating the existing system, the comparison process also serves as a form of gap analysis, helping to determine that the employer's written policies and programs are consistent with what is actually occurring in the workplace. From this gap analysis, action plans may be developed. All of this must be performed objectively and reliably, and be accurately documented, including action items and opportunities for further improvement.

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Implementing a Health and Safety Management System

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Evidence of Success

- **OSHA**—According to OSHA, "the average VPP worksite has a lost workday incidence rate 52 percent below the average for its industry," with reductions being observed as a site begins the VPP application process.
- **VPPPA**—According to the Voluntary Protection Programs Participants Association, more than 500,000 U.S. workers are directly impacted by VPP.
- **ACC**—The American Chemistry Council, which uses the Responsible Care standard, has found that based on OSHA statistics, ACC members are 4.5 times safer than the average of all other manufacturing industries combined. In its Occupational Injury and Illness Report (OIIR), the ACC showed a 16 percent improvement in the overall safety of member company employees in 2002. ACC cites Responsible Care as an important element of this gain. Small, medium, and large companies all showed improvement, with fewer recordable injury cases and fewer incidents resulting in lost workdays. ACC companies have seen a 42 percent improvement in employee safety since 1993.

Document Review

To provide a thorough understanding of the current system and its recent implementation history, reviews of health and safety-related documents will generally go back about five years. Documents older than five years (such as occupational health monitoring records) are important indicators of past system performance, but may not be a good reflection of the current health and safety management system. Many older records are required to be maintained by OSHA and/or other regulations, so procedures for identifying and maintaining health and safety-related records should be specified by the employer's own record retention guidelines. These procedures should be included in the review process.

- Corporate and local health and safety policy statements and procedures—These are reviewed to determine their adequacy and applicability, and to verify that they are current. Many health and safety management system initiatives "die on the vine" due to a lack of visible support from corporate and/or facility top management. An initial step must be to assess the support of top management.
- Written programs required by regulations—These include hazard communication, hearing conservation, lockout/tagout, and the many others required by OSHA and/or state regulations.
- Supplemental health and safety procedures—It is very important that employers follow through on what their written procedures state. Failure to do so can be a significant source of potential liability, and an indicator of a poorly developed/implemented procedure. Additional investigation into the root cause(s) of any such failure may provide excellent information that can form the basis for future health and safety management systems.
- Accident/incident records, first aid reports, investigations, OSHA citation/inspection records, and workers compensation claims—These are reviewed for accuracy, thoroughness, and to identify trends that might suggest weaknesses in the health and safety management system. (The employer should be able to demonstrate that it is doing this trend analysis periodically.)

Other documentation that is reviewed may include (but is not limited to) hazard assessments, health and safety training records/course materials, expired hotwork and confined space entry permits, industrial hygiene programs and monitoring records, and medical records. In addition, safety committee meeting minutes and the minutes of other internal meetings addressing health and safety matters should be considered, and employee/management involvement should be evaluated. Recent management correspondence and memoranda following up on safety committee recommendations may indicate the level of management support for the health and safety effort.

Interviews

Interviews with employer personnel at all levels are critical components of the health and safety management evaluation, and should be conducted with the approval of the employer. The number or percentage of personnel to be interviewed at each level should be determined in advance. A set of a few interview questions should be prepared in advance and asked of all those interviewed. An interviewer should also be able to ask other questions that come to mind during the evaluation. Interviews serve several purposes:

- Confirm what has been read in the document reviews—Corporate staff or consultants often write policies and procedures with very little involvement from the persons who will implement the procedures. As a result, actual practice may not reflect written policies and procedures. This may be discovered during interviews, and corrective action may be recommended.

- Identify differences between employee and management perceptions—When employee and management perceptions of the health and safety management system are not aligned, it is usually the result of a lack of sustained active commitment (i.e., value communication) to health and safety on the part of senior management. It can also be that middle management has not yet accepted and endorsed senior management's position on health and safety management, and as a result is not fully implementing or enforcing it. Regardless of the cause, this situation must be identified so it can be corrected.
- Convey the employees' overall impressions—A trend of unfavorable perceptions of the health and safety management program indicates a weakness somewhere that needs to be identified and resolved.

Facility Surveys

Facility surveys are as important to health and safety management evaluations as record reviews or interviews. They also require that the surveyors have substantial health and safety experience in the anticipation, recognition, evaluation, and control of workplace hazards. Facility surveys:

- Confirm information gathered during document reviews and interviews.
- Identify hazards and assess their control—A facility survey will attempt to discover if all significant hazards (including those that cannot be readily observed but can reasonably be anticipated) are under active risk management by the facility. The survey will confirm that the facility has accurately identified significant hazards, and has implemented appropriate engineering or administrative controls. It also confirms the existence of a hazard analysis process, which is critical to an effective health and safety management system. A hazard analysis process should be applied to all major new or significantly modified facilities and equipment, jobs with high injury rates, and jobs with the potential for serious injuries. Certainly, a hazard analysis must be performed on any required system such as those covered by OSHA's Process Safety Management standard.
- Evaluate regulatory compliance for the identified hazards—This includes the adequacy of written programs and training that have previously been reviewed during the document reviews and interviews. It involves observing employees performing their jobs, with special attention to engineering controls, work practices, and the use of personal protective equipment.
- Allow for evaluations of the quality of self-inspections, preventive maintenance, housekeeping, and general conditions—These are all major considerations during the evaluation of health and safety management systems.

Summary

Effective evaluation of health and safety management systems is an in-depth process requiring a great deal of training and experience. However, implementing or improving a health and safety management system may have a significant payoff in the form of fewer accidents and reduced injury and illness-related losses. The evaluation process not only establishes that an appropriate health and safety management system is in place, it also confirms that policies and procedures reflect what is actually happening in the workplace. ■

Endnote

1. The U.S. Bureau of Labor Statistics (BLS) reports approximately 6,000 occupational deaths and another 6,000,000 injuries and illnesses annually in the United States, resulting in nearly 2,800,000 lost workdays. The Liberty Mutual Workplace Safety Index estimated that occupational accidents cost employers $40,100,000,000 in 2001. The International Labour Organization (ILO) estimates there are 1,200,000 occupational deaths resulting from 250,000,000 accidents and 160,000,000 illnesses worldwide each year.

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Second-Injury Funds: Still a Valuable Cost-Containment Tool

by Mark J. Nevils, J.D.

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Nevils has litigated and managed the litigation of numerous second-injury fund claims and was the lead counsel in several ground-breaking decisions against the Massachusetts Second-Injury Fund.

Background to Second-Injury Funds

The debate continues on whether workers compensation second-injury funds (SIF) fulfill their intended purposes. The fact remains, however, that these funds still exist in many jurisdictions, and provide employer/carriers with a very valuable cost-containment tool when properly handled.

As the workers compensation claims process becomes increasing segmented, more companies are dedicating personnel to in-house programs or outsourced vendors to achieve maximum cost containment. An estimated $800 million is paid out annually from these funds across the country, primarily by either reimbursement to the carrier or directly to the claimant.

The first second-injury fund was created in New York in 1916. Such statutes, however, gained more popularity across the country in the 1940s when a National Model Code was promulgated in large part to help combat employment discrimination against disabled WWII veterans. Many jurisdictions adopted a variation of the model code to fit within their own workers compensation scheme. As these statutes found their way into each jurisdiction's workers compensation system, they developed various other names, e.g., special disability funds, subsequent injury trust funds, apportionment funds, workers compensation trust funds, handicap reimbursement funds, etc.

As the workers compensation claims process becomes increasing segmented, more companies are dedicating personnel to in-house programs or outsourced vendors to achieve maximum cost containment.

These funds were created to relieve a portion of the employer's/insurer's claims costs when the employer hired a claimant with a pre-existing disability and that claimant then suffered a "second" injury, creating a greater disability because of the combined effects of the prior and subsequent disabilities. Prior to second-injury fund statutes, such a situation could create a disproportionate claim cost as it related to the industrial injury; therefore, reluctance existed on the part of employers to hire anyone with a pre-existing medical condition.

Initial funding mechanisms for these funds were essentially inadequate since they had little relationship to the actual exposure of the second-injury fund. Today, in most jurisdictions, employers/insurers are required to pay a yearly assessment based on a percentage of premiums written or losses paid the previous year. In turn, the funds pay, directly to the claimant or reimbursement to the carrier, for a portion of the claims costs when a prior impairment combines with the industrial injury to create a greater disability and claims exposure.

For various reasons some of these funds have had a volatile life within their jurisdictions' workers compensation systems and several such statutes have been repealed. Surviving funds, however, are quite active and share many of the same characteristics while remaining consistent with their own jurisdiction's workers compensation statutes.

Common Second-Injury Fund Elements and Issues

The following are some common elements and issues found in today's more active second-injury funds.

Pre-Existing Medical Condition

Most second-injury fund statutes state that in order to prove a claim, there must be evidence that the claimant suffered from a known pre-existing impairment arising from a prior accident, disease, or congenital condition and that this impairment was diagnosed before the date of the second injury.

The prior impairment is generally required to have been permanent and some statutes, such as Arizona and Nevada, actually require the prior permanent impairment to qualify as a specified percentage under the AMA guidelines (10 percent and 6 percent, respectively).

Unfortunately, many qualified claims do not get filed because there is no existing documentation of a previous rating for the prior permanent impairment. However, if a statute allows prior impairments to be from any cause, then many of these conditions will not have prior ratings and, therefore, such evidence needs to be obtained from medical experts, as opposed to being found in the files or prior medical records.

To further qualify claims under this element, many statutes will list a number of exclusive or presumptive prior impairments. It is important to note the difference between an exclusive list and a presumptive list because when a list of prior impairments is merely presumptive, a claim may still be filed with the fund if the prior impairment qualifies outside of the list.

Another qualifier commonly found with the prior impairment is that the impairment be a hindrance or obstacle to employment. This definition is usually inserted by stating that prior impairment "is or is likely to be" a hindrance or obstacle to employment or "an obstacle or hindrance to employment should the employee become unemployed." As a somewhat subjective qualifier, "hindrance" can be satisfied numerous ways, including evidence of the claimant's vocational background, medical expert records and opinions, employer statements, or a combination thereof.

Notice to Fund

Almost all active second-injury fund statutes have a notice provision that require the employer/insurer to put the fund on notice of a potential claim within a specified time, e.g., within 100 weeks from the employer's first report of injury. Failure to notify the fund within the statutory time limit is generally a complete bar to fund liability.

Notice can be as simple as filing a letter. Some jurisdictions, however, require the notice to include more specifics about the potential claim, and failure to include required information can bar a claim at a later date. For example, New York's fund requires notice within 104 weeks of the claimant's disability, and the form must specify the prior impairment upon which the employer/insurer will rely when it files the claim with the fund at a later date. Failure to list the proper prior impairment on the notice form can be corrected within a certain amount of time. If it is not corrected, then the employer/insurer will not be able to use that prior impairment later on to prove its claim.

Employer's Knowledge of the Pre-Existing Medical Condition

Most, but not all, second-injury fund statutes contain language stating that the employer must have knowledge of the prior impairment before the date of the second injury. Alaska, Arizona, Georgia, Louisiana, New Hampshire, Nevada, South Carolina, and Massachusetts are examples of active SIF statutes with a strong employer knowledge element, although Massachusetts did not require employer knowledge until it changed its workers compensation statute in December 1991. Conversely, New York did have an employer knowledge element in its statute until 1987 when that requirement was eliminated.

Notice can be as simple as filing a letter. Some jurisdictions, however, require the notice to include more specifics about the potential claim, and failure to include required information can bar a claim at a later date.

A common misconception about the employer knowledge element is that the employer's knowledge of the prior impairment must be ascertained at the time of hire. Most statutes actually allow employer knowledge to take place at any point before the time of the second injury. Massachusetts is one of the only "knowledge" jurisdictions that provides a time limit for employer knowledge from the date of hire or retention in employment (30 days). Allowing knowledge to be ascertained after the date of hire is one of the ways that the second-injury fund statutes try to dovetail with disability discrimination laws.

Jurisdictions, such as New Hampshire, Alaska, and Nevada, also require the employer's knowledge to be corroborated with some documentation from the employer. The purpose of written documentation is to verify the employer's statement that it knew of the prior medical condition before the second injury. Unfortunately, such a strict requirement disqualifies many deserving claims in these jurisdictions. Many employers do not document their employees' prior medical conditions although they are well aware of a prior disability.

Combination of Disabilities

Most funds require medical evidence to prove that the claimant's disability after the second injury is substantially greater because of the combined effects of the prior and second injury than it would have been had the second injury happened alone. A common misconception of this element is that the prior disability must be to the same body part as the second injury, and that the second injury must somehow directly aggravate the prior disability. Direct aggravation is not always required, and many different combinations of disabilities can give rise to a fund claim.

Certain funds will even promulgate a form containing questions to be answered, preferably by the treating physician, before they will approve a claim. Careful review should be taken of these forms, as they do not always conform to the requirements under the statute. Most claims can be perfected by an expert report whose opinion mirrors the statutory language, whether or not it is the treating physician.

Point of Fund Liability

The point at which the fund has potential liability varies from state to state. Georgia, Louisiana, and South Carolina's second-injury funds allow reimbursement for medical benefits after a certain monetary threshold ($5,000, $5,000, and $3,000, respectively) and indemnity after a certain amount of weeks of indemnity has been paid on the claim. For example, in Georgia, if all the statutory requirements are met, then the Subsequent Injury Trust Fund will reimburse the employer 50 percent of all medical bills paid between $5,000 and

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$10,000, and then 100 percent of those bills thereafter in addition to 100 percent reimbursement for all indemnity benefits paid after 104 weeks of disability.

New Hampshire's statute allows for reimbursement of almost all medical and indemnity benefits after the first $10,000 of those benefits combined. Fifty percent of payments are reimbursed within the 104 weeks of disability, and 100 percent thereafter.

Some statutes will only allow second-injury fund liability if the claimant receives permanent benefits as in New York, New Jersey, Massachusetts (after December 1991), District of Columbia, Arizona, and longshore claims.

Some funds are liable for indemnity and medical benefits and some for indemnity only. A few funds limit indemnity liability to disability claims and exclude dependency benefits on death cases, such as New Jersey.

Types of Funds

The two major types of second-injury funds are reimbursement funds and take-over funds. In both of these situations, the employer/insurer is able to significantly write down any future reserves on a claim when the fund becomes liable. In certain jurisdictions, such as Georgia, South Carolina, and Louisiana, the fund requires the employer/insurer to sign an affidavit that it is writing down its reserves on the claim before a reimbursement check will even be issued.

Reimbursement Funds

Most of the funds noted above reimburse the carrier for indemnity and medical benefits made to or on behalf of the claimant. In those funds, once fund liability has been established, the employer/insurer remains the primary claims handler and must request periodic reimbursements from the fund (e.g., quarterly) for certain payments made on the claim.

More proactive reimbursement funds will want to be involved in any workers compensation settlement discussions between the claimant and the employer/insurer. Some jurisdictions, such as New Hampshire and New York, require the fund to be involved before the settlement between the claimant and the employer/insurer. In these jurisdictions, if the fund is not involved, then any reimbursable amount within the settlement cannot be recovered.

Also in New York, if the fund's liability has been established, it must be involved with any third-party settlement. Not all funds want to be involved at this level, but most funds will review any third-party settlements and take appropriate credits so as not to reimburse an employer/insurer for monies on which it has already received recovery.

> ■ *Some statutes will only allow second-injury fund liability if the claimaint receives permanent benefits . . .*

Take-Over Funds

Certain second-injury funds will pay the claimant directly once its liability has been determined. These funds can be referred to as "take-over" funds because the fund literally takes over the compensation payments from the employer/insurer. In New Jersey, for example, once the fund's liability has been established, it can pay the claimant's permanent and total benefits for the life of the claim. Although, the employer/insurer remains liable for the medical aspect of the claim, it can write down the indemnity reserves, which is usually a significant amount.

A charge to funds exists when a non-self-insured employer in a monopolistic jurisdiction is allowed to "charge" that portion of the claim cost caused by a combination of a prior and second disability, to a fund in that state so that the cost for that claim will not be calculated into the employer's experience modification rate. In Ohio, for example, that portion of the claim that otherwise would have been charged to the employer's experience is deducted from that claim and charged to the Statutory Surplus Fund.

Conclusion

There are many active second-injury funds in existence today, and perfecting all claims takes focused time and effort. Strict attention should be paid to the statutory requirements along with any corresponding regulations. Although no two funds are exactly the same, they were all born from the same intent. Therefore, a sound knowledge of several different funds will go a long way in handling any one jurisdiction's claims. ■

The Write Stuff

by Charles H. Morgan, J.D., CPCU, CLU, CSP, ARM

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Morgan earned a B.A. and M.A. at Lehigh University, and a J.D. at Dickinson School of Law. He is admitted to the Bar in Maine and Pennsylvania; serves on the Editorial Advisory Council of *Risk Management* magazine; and is currently engaged in the revision of the Insurance Institute of America's Associate in Risk Management curriculum . . . and, of course, he is the editor of your *LCQ!*

Editor's Note: We include this article because the message is as important today as it was when the article appeared in the May 2000 issue of *Rough Notes* magazine, and is reprinted here with permission.

Introduction

A front-page article in the *Wall Street Journal* (February 4, 2000) highlighted some of the perils confronting employers with respect to electronic communications sent and received by their workforce. The article, entitled "Those Bawdy E-Mails Were Good for a Laugh—Until the Ax Fell" recounted an incident at the *New York Times*' backroom operation in Norfolk, VA, in which 22 employees were summarily terminated. While the *Times* is obviously reluctant to offer more than sketchy details about the episode, the fact that the firm's chairman, Arthur O. Sulzberger, Jr., was personally involved in the disciplinary measures suggests the gravity of the incident from management's perspective.

What was the nature of the offense? Apparently there was widespread abuse of the company's policy of "reasonable" personal use of the firm's electronic communication systems. The reported policy on e-mail reads as follows.

> . . . computer communications must be consistent with conventional standards of ethical and proper conduct, behavior and manners and are not to be used to create, forward or display any offensive or disruptive messages, including photographs, graphics and audio materials.

As reported in the *Journal* piece, however, the terminated employees are alleged to have engaged in the widespread creation and circulation of sexually explicit material that ranged from the "sophomoric" to the "pornographic." While the response at first appears to be a policy of zero tolerance on sexual harassment, the issue is actually much more complex than this. This article will detail the law and related issues affecting this emerging source of concern, and will then proceed to present the essential components of a policy on electronic communications that should be adopted by all prudent employers who want to successfully navigate this minefield of potential liability.

The Legal Environment for e-Mail

The conflict inherent in the technology behind electronic communications can be viewed as pitting the individual rights of the employee against the legitimate prerogatives of management in terms of the day-to-day operations of the firm. That is, all employees have a reasonable expectation of privacy in the course of their daily duties, but this right must be circumscribed to a certain extent in terms of compliance with company policies and procedures affecting personal behavior.

As a matter of common law this right to privacy is enumerated in Section 652B of the Restatement (Second) of Torts, which details the ways in which a person's personal "space" may be invaded. They are briefly "bugging" a person's phone, misappropriation of a person's name or likeness for financial gain, unreasonable publication of personal matters, and presenting a private person in a false light that tends to cause embarrassment to that individual. Of these four common law torts, the first is the principal source of litigation in the realm of corporate electronic communications.

While the case law in this field is in its infancy, there are certain decisions that provide useful guidance in an effort to balance the competing interests involved. In *Smyth v The Pillsbury Company*, 914 F. Supp. 97 (E.D. Pa. 1996), for example, the plaintiff was fired for "inappropriate" comments transmitted by company e-mail. Among his indiscretions the plaintiff referred to the sales management

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team as a bunch of "bastards" in a memo to his supervisor. In response to this pattern of offensive behavior the management read all of his correspondence, which they then used as the basis for summary termination. Not surprisingly the plaintiff countered by filing suit for an invasion of his privacy.

In finding for the defendant employer the court held that by venting to his supervisor in such an unseemly manner the employee had clearly waived any reasonable expectation of privacy with respect to the content of his communications. Furthermore, the court held that even if a reasonable expectation of privacy survived, no reasonable person would find that the reading of the e-mail constituted a gross intrusion into the plaintiff's privacy. This case is fairly typical of the recent decisions in this area by striving to balance the legitimate expectation of employee privacy against the sensitivities of a "reasonable" person.

In terms of an employer's right to monitor employee communications, the courts have fashioned two theoretical models, the "context" approach and the "content" analysis. In the first situation an employer may justify e-mail monitoring if notice has been provided to the workforce and the level of surveillance appears to be reasonable. That is, to the extent that a firm insists that all electronic communication be for business purposes only, it may be argued that it has the right to enforce this policy by surreptitious monitoring of the employees' phone calls and e-mail.

In the "content" approach the focus is likewise on the distinction between personal and business communication, but the issue is more a function of what the employee is communicating than how he or she is spending their time. That is, in the event that an employee is discovered to have made defamatory, harassing, or otherwise unacceptable comments, such employee may be properly disciplined without regard to his or her right to privacy. This was the case in the *New York Times* incident.

Employer Liability and e-Mail

With respect to the need for employers to develop a formal electronic communications policy in order to shield themselves from liability, there are several key points to consider. First of all, any such policy should be in writing and thoroughly distributed to all members of the firm. While it should appear prominently in the employee handbook, it should be circulated by other means as well in order to assure that there can be no misunderstanding. Also, in order to reaffirm management commitment to other policies it should incorporate by explicit reference the firm's policies on sexual harassment and nondiscrimination in all forms.

> ■ *. . . the policy should state that the employer reserves the right, but assumes no duty, to monitor all employee communications at all times during the employment relationship.*

In order to defuse any claim of invasion of privacy, it is absolutely essential that the policy be clear that the means of electronic communication be the exclusive property of the employer. Also, the policy should state that the employer reserves the right, but assumes no duty, to monitor all employee communications at all times during the employment relationship. Employers should also expressly reserve the right to install software that blocks access to "chat rooms" or other inappropriate web sites, or to impose similar reasonable restrictions on electronic communications.

Finally, employers should develop a rational and coherent policy of document retention and destruction. By so doing employers can shield themselves from allegations of selective document "shredding" due to improper motives in anticipation of impending litigation.

Conclusion

This article has merely scratched the surface of a vexatious topic that is proving to be a nightmare in terms of risk management strategies for firms in every industry. The *Journal* piece on the *Times* experience has neatly summarized the source and scope of the problem with the following observation.

As technology blurs the line between private and work time, workers often feel entitled to use company computers for personal matters. Lulled by e-mail's informality and ease of use, they may forget that they are leaving a record of exchanges that in the old days were snickered over at the water cooler, then forgotten.

Clearly it is the obligation of every firm's management to assure that such mental lapses do not occur on their watch, and they must take affirmative steps in order to avoid this electronic pitfall. ■

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The Standardization of Loss Runs

by Christopher D. Conti, CPCU, CSP, ALCM, ARM

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The analysis of loss runs by those individuals that benefit from the report is critical to determining an employer's past injury sources so a corrective action agenda can be established. The users of loss runs—underwriters, agents, loss control reps, attorneys, reinsurers, and others—represent a broad cross-section of education and experience. Therefore, simplification of these valuable reports will serve to expedite an understanding of the data they contain. The review of loss runs, prior to the actual visit of an account, can help steer the loss control professional to the problem area, and that improves efficiency as we focus immediately on elimination of the injury source. Loss runs, or claim reports, vary from company to company, each with a different style, font, text, and format. Therein lies the problem as loss control workers need to spend additional time reviewing each loss report to gain the appropriate level of understanding before consulting can begin. This may also frustrate claims professionals as they may have to review loss reports from other companies for subrogation purposes and historical account analysis.

Just as there are indirect costs associated with injuries, the same holds true with service efficiency. The indirect—wasteful—cost can be attributed to lack of clear, easy-to-understand loss runs. This indirect cost from lack of efficiency transcends beyond the loss control rep. Also, it negatively affects underwriters, employers, and agents, as they have to pick through the data to make sense of it. If we look at other documents that loss control personnel have to review we readily find standardization in the documents of:

- the ACORD application
- the workers compensation contract/policy
- material safety data sheets
- in general, safety program structure
- experience modification factor worksheet

Perhaps carriers want loss runs to be hard to understand as the font may not fax well or the copy is poor because of a company logo in the middle. Perhaps they feel this will hinder their information from being readily comprehended by competitor agents and carriers. I say they miss the intent of why a loss run is generated at all, that is to inform the user of needed data. I believe that claims professionals would agree that the more we as an industry can deliver clear and understandable information to the people that need the information, the better we fulfill the needs of the organization.

The main push for a standardized loss run document should come from the professionals who are responsible for that side of the house.

I would suggest a simpler, easier way to do business and enhance effectiveness. *I recommend a national voluntary standard loss report form with a pre-set font size and format*. Complex data tables need simplicity to invite analysis. An employer may get his or her loss runs, which we all know are critical to review to take corrective preventive action, but may not spend a fair amount of time with the document as it is too complex to understand. A loss control engineer may not be able to read the small print and miss a loss source that has caused a past injury. In addition, terms such as incurred, reserved, paid, allocated loss adjustment expense, and unallocated loss adjustment expense should have common definitions that are accepted industry-wide. Claims professionals could give solid insight into what information is most useful to report users.

The main push for a standardized loss run document should come from the professionals who are responsible for that side of the house. Claims managers, claims supervisors, professional claims organizations, MIS people, and industry leaders must deliver information that is easier to read and comprehend. Third-party administrators can play a role here in the development of a national, voluntary standard document form for claims listing. Perhaps the NCCI could consult with industry organizations to accomplish an electronic report that not only fulfills the informational needs of the reader but also allows for unit stat report data needs to be met. This would mean one data entry accomplishes two tasks, loss run generation and unit stat completion. That would save time and money, and simplify a process.

After reviewing loss runs for 15 years in the industry, the best loss report I have seen is the simplest one. This carrier has a top cover sheet that has a summary on it of prior years' activity and sets out the general information of account such as: policy number, value date of losses, written premium, earned premium, incurred total, paid amounts, reserved amounts, and loss ratio. The next pages are a block table with only the heading of employee information, which, all in the same block, contains the injured worker's name, age, social security number, and months on the job. The next large block is titled claim information and contains the claim, number of days to report (lag time), type of claim, medical only or lost time, and status, open or closed. The next block provides sufficient room for an adjuster to write out what happened in more detail than just two to three words such as hurt back from lifting.

The report states, as the employee went to lift a 57-pound bag of rice the worker felt a sharp pain on the right side. Employee works in the shipping department. The beauty is in the simplicity. This report is of high value as it delivers more information to the end user. In communications, it is important to put the message in the context of the

person you are trying to communicate with. As an extreme example, if we were communicating with a deaf person we would use sign language. I think most loss control engineers, agents, consultants, and employers are analytical people who would prefer simple, standard, easy-to-read documents. We all want our employer-customer to read and take corrective action on loss runs. Think about when employers change carriers—they have to re-orient themselves to a new set of loss run style and they may invite apprehension about giving the report the due diligence it deserves. However, if employers got the same information presented in the same format among carriers, they could readily isolate problem areas with a quick read of the document. Employers would become familiar with where to seek answers from the document. That may invite more dialogue, conversations, and questions about the adjudication of the claim. These conversations would lead to understanding and progress. Yes, I am stating that easy-to-read, standard loss runs would improve closure rates as employers become acclimated with crucial details.

Another opportunity for improvement in the presentation of loss runs to all concerned parties is to give information that can lead to corrective action. In my opinion, one big problem with loss runs is the fact that it *only* gives information about what has happened on the worksite. It is a reactive document. I believe a better approach would be to give the prevention technique on a separate sheet so the employer can make corrective action. For example, eye injuries could be coded with a number such as *eye001*. Let's assume an employer has several eye injuries listed on the loss report. With computer technology, these loss sources can be identified, via the eye001 code, and automagically, yes, automagically, a document titled "How to prevent eye injuries" is attached to the loss report. If possible, the OSHA standard on PPE, which covers eye protection, rides with the loss report. Why not include a web site address where employers and/or safety managers can go to get such prevention information? The point is that it is not enough to list the problems, i.e. the claims, but to give the corrective control techniques would go further in reducing loss frequency.

The ability of a person to readily contact needed personnel is another opportunity for improvement. If it were standard practice to have contact numbers on loss runs, a higher level of prompt communication would be the result. The adjuster's phone, fax, and e-mail would allow questions and statements about claims to be transmitted.

The same is true with the need for the loss control person and case managers' contact information. If it were readily available it would invite communication that leads to expeditious claim closures and/or lower reserves.

Summary

Suffice to say, the designers of loss runs have an opportunity at hand to improve the intended communication of the information, save precious time for the readers of loss runs, and provide a proactive element to a reactive document. Also, as part of the standardization, contact information of claim handlers and prevention personnel should be on the loss run to facilitate prompt communications. Professional claims associations should consider taking a leadership role in the transformation to a national standard loss report document. The benefits would be meaningful and widespread. ■

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